

454 10/09/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN CITY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 919 MEDICAL PARK DRIVE MOUNTAIN CITY, TN 37683		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>Mountain City Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>F441</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #8 has been assessed by the DON and the MDS Coordinator. Nursing Care Plan and the C.N.A care plan has been reviewed and revised as indicated related to incontinent care. Incontinence care in-service training will be initiated on 9/2/11 by Director of Nursing or Assistant Director of Nursing. All PRN, full time, and part time Certified Nursing Assistants and Licensed Practical Nurses (PRN, Full Time & Part Time) will participate in training which will be completed by 9/23/11. (Facility has no agency nursing staff)</p>	10/3/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Diana Branch

Administrator

9/6/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SEP 07 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2011
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to follow the infection control policy for one (#8) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on August 20, 2011, with diagnoses including Cerebral Palsy, Hypertension, and Arthritis. Medical record review of the hospital History and Physical revealed the resident was dependent for activities of daily living.</p> <p>Observation on August 22, 2011, 10:45 a.m., in the resident's room, revealed two CNA's (certified nursing assistant) providing incontinence care after an episode of stool. Continued observation revealed the following: CNA #1 wiped the buttock with a gloved hand; had visible stool on the glove and wiped the glove on the incontinence pad; using the same gloves, removed the incontinence pad and placed a clean incontinence pad under the resident; placed a clean brief; repositioned the resident; adjusted the resident's pillow; adjusted the linen; gathered the dirty supplies and opened the door; placed dirty supplies in the dirty linen cart.</p> <p>Review of the facility's policy Handwashing/Hand Hygiene revealed "...n. Before and after assisting a resident with toileting (hand washing with soap and water)..."</p> <p>Interview with the Director of Nursing on August</p>	F 441	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Facility wide assessments and reviews of incontinent residents have been conducted by Director of Nursing, Assistant Director of Nursing and the MDS Coordinator. Nursing Care Plans and C.N.A. care plans have been reviewed and revised as indicated related to incontinent care. Any resident receiving incontinence care will be considered at risk of the deficient practice.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.</p> <p>The Director of Nursing or Assistant Director of Nursing will monthly observe incontinence care and ensure competency by one Certified Nursing Assistant on each hall and each shift for six months beginning <u>9/23/11</u>. The Director of Nursing has inserviced the licensed nursing staff that they are to monitor on daily rounds and observe incontinent care for acceptable practices. The Staff Development Coordinator will review incontinence care competency annually per policy with each Certified Nursing Assistant. All newly employed Certified Nursing Assistant will receive incontinence care training during orientation and competency will be verified.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place?</p> <p>The Director of Nursing or Assistant Director of Nursing will monthly observe incontinence care and ensure competency by one Certified Nursing Assistant on each hall and each shift for six months beginning <u>9/23/11</u>. Findings will be reported to the Process Improvement Committee monthly. Monitoring during daily rounds by Licensed Nursing Staff will be on going.</p>		

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F 441	Continued From page 2 24, 2011, at 8:45 a.m., in the 300 hallway, confirmed the staff are to remove gloves and wash the hands after providing incontinence care.	F 441			

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